MAPB-087-005-0 Date: 9/1/87

Community Care Services

FORM APPROVED
OMB NO 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

		MEDICAID NO ;	(SP	AMPUS ONSOR'S ESNI	CHAMPVA (VA FILE NO)		FECA BLA	CK LUNG		OTHER (CERTIFICATE SSN)
PATIENT'S NAME ILAST	NAME FIR	PATIEN	IT AND	INSURED (SU	BSCRIBER) I					
Recipient	_	_	(IAL)	2. PATIENT'S DATE O		3 INSU	ED'S NAME	LAST NAM	E. FIRST N	AME, MIDDLE INITIAL
FATIENT'S ADDRESS (ST				MM DD	YY		ame			
		, orace are coper				INCLL	RED'S I.D. NO	(FOR PROTERS)	GRAM CHE	CKED ABOVE
609 Willow				MALE X	FEMALI	· 1	234567	89 d		
Anytown WI	5372	5		7 PATIENT S RELATIONSHIP	TO the then					
•						8 INSURED	S GROUP NO (PH GROUP NAM	E OF FECA CL	AIM NO
LEPHONE NO				SELF SPOUSE	CHIFD Q	MER	INSUE	EO 15 EMB: ~1	D 4ND 504	RED BY EMPLOYER
OTHER HEALTH INSURANCE COVER PLAN NAME AND ADDRESS AND F	RAGE ENTER	NAME OF POLICYHOLDER AN	10	10 WAS CONDITION RELATE	D TO	1) INSURED	S ADDRESS IST	H PLAN		
TOTAL AND PODRESS AND P	rotic ron mi	FUICAL ASSISTANCE NUMBER	J	A PATIENT'S EMPLOYMENT					In CODE	,
OI - D			·	YES T	X NO			^		
01 - 0					[21]			- 8		
			i	B ACCIDENT		TELEPHO 11.a	INE NG	Charles		
				AUTO	OTHER		ACTIVE	CHAMPUS S		BRANCH OF SERVICE
				_		STATUS	RETIRE	<u> </u>		
PATIENT'S OR AUTHORIZED PERSO I AUTHORIZE THE RELEASE OF AN OF GOVERNMENT REMERTS STATE				CLAIM 1 ALSO REQUEST PAYER	IFNT	13 AUTHO	RIZE PAYMENT O	E MEDICA: BEI	EFITS TO UNI	DERSIGNED
OF GOVERNMENT BENEFITS EITHE		ON TO THE PARTY WHO AL	TENIS MOSIUMM	ENT BELOW	•	PHI SICA	IN OR SUPPLIER	POR SERVICE	DESCRIBED BE	LDW .
NED / / / / /	/ / /	<u>////</u> //	' / / ,	/	11111	SIGNEDAINSU	HED OR ANTHON	lizenbendhi	///	11111
			PHYSIC	AN OR SUPPL	IER INFORM			accy cryoni		
DATE OF	ILLNESS	IFIRST SYMPTOMI OR INJU IT; OR PREGNANCY (LMP)	#TY 15	DATE FIRST CONSULTED T	YOU FOR THIS	16 IF PATIE	NT HAS HAD S	AME OR	AVE E	16. IF EMERGENCY
	1				111	SIMILAR ILLNESS OR INJURY, GIVE DATES CHECK HERE				
DATE MATIENT ABLE TO RETURN TO WORK	18. DATE	ES OF TOTAL DISABILITY		_		DATES OF PA	RTIAL DISABIL	TY	<u> </u>	
NAME OF REFERRING PHYSICIA	FROM /	/ / / / /	/ / _{ТМ}	10UGH / / /	1111	/ FROM / 1	1///	1//	THROUGH	//////
THE OF REFERENCE PRISICIA	AN ON UTHE	H SOURCE MED PUBLIC HEA	ALTH AGENCY			20 FOR SEI	RVICES RELATE	D TO HOSPITA	ALIZATION G	VE
NAME AND ADDRESS OF FACIL	ITY WHERE	EFFICER BENDERED OF			ADMITTED	- O SCHARGED				
THE RESERVE OF PACIE	OIT WHERE	SENVICES HENDERED IN O	THER THAN H	OME OR OFFICE)		22 WAS LA	BORATORY WO	RK PERFORM	ED OUTSIDE	YOUR OFFICE?
A DIAGNOSIS OR NATURE OF I	ILLNESS OR	HUURY RELATE DIAGNOSI	S TO PROCEDU	DE IN COUNTY D BY BOSE		YES	NO	CHARGES.		
							•			
V68.9 Unspect	iriea	Encounter	tor Ad	ministrativ	e Purposes	•	EP:	TO	YE	s no
							FAI	HILY PLANNIN	G YE	S NO
						1	PRIOR AUTHORIZATI	·		
		C FINITY DESCRIPT ON	CEDURES ME	CICAL SERVICES OR SUPPLI						
DATE OF SERVICE	PLACE	FURNISHED FOR FAC	CATE CHES	NOWE BENAICES ON POSSE	ES				\neg	M LEAVE BLANK
DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE	H DATE GIVEN		1	D DIAGNOSIS	E	DAY		H LEAVE BLANK
пом то	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS CODE	E CHARGES	DAY	G •	M LEAVE BLANK
мом то	OF .	PROCEDURE CODE	IEXPLAIN		RCUMSTANCES	DIAGNOSIS	CHARGES	DAY OR UNIT	G •	M LEAVE BLANK
мом то	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	M LEAVE BLANK
то мом	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	M LEAVE BLANK
Ом то	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	M LEAVE BLANK
Ом то	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	H LEAVE BLANK
Ом то	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	M LEAVE BLANK
ОМ ТО	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	M LEAVE BLANK
то мом	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	M LEAVE BLANK
лом то	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	H LEAVE BLANK
пом то	SERVICE	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	
701-29/88	Service Ø	PROCEDURE CODE	IEXPLAIN	UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS		DAY: OR UNIT	S TOS	Patient
701-29/88	SERVICE	PROCEDURE CODE INDENTIFY W6300	IEXPLAIN CCO	unusua, services or ci Administrat	ive Fee	DIAGNOSIS	XX	XX 29	S TOS	Patient Spenddown
701-29/88	SERVICE	PROCEDURE CODE INDENTIFY W6300	IEXPLAIN CCO	Administrat	ive Fee	DIAGNOSIS	XX	XX 29	S TOS	Patient Spenddown 29 MALANCE DUE
701-29/88	SERVICE	PROCEDURE CODE INDENTIFY W6300	IEXPLAIN CCO	Administrat	ive Fee	DIAGNOSIS CODE 27. TOTAL C	XX XX ARGE XX NS SUPPLIER	XX 29	S TOS 9	Patient Spenddown 29 BALANCE DUE
701-29/88	SERVICE	PROCEDURE CODE INDENTIFY W6300	IEXPLAIN CCO	Administrat	GOVERNMENT K	DIAGNOSIS CODE 27. TOTAL C	XX	XX 29	S TOS 9	Patient Spenddown 29 BALANCE DUE X XX.XX
SIGNATURE OF PHYSICIAN OR SICHEDENTIALS; II CERTIFY THAT	SERVICE D UPPLIER IIIN THE STATEMENT THEREOF	PROCEDURE CODE INDENTIFY W6300 LUDING DEGREE(S) OR LENTS ON THE REVERSE AL	IEXPLAIN CCO	Administrat	GOVERNMENT K	27 TOTAL CHARLES AND TELE	XX NS. SUPPLIER: PHONE NO	XX 29	S TOS 9	Patient Spenddown 29 BALANCE DUE X XX.XX
SIGNATURE OF PRIVISICIAN OR SICREDENTIALS: II CERTIFY THAT THIS BILL AND ARE MADE A PAR	SERVICE D UPPLIER IIIN THE STATEMENT THEREOF	PROCEDURE CODE INDENTIFY W6300 LUDING DEGREE(S) OR LENTS ON THE REVERSE AL	IEXPLAIN CCO	Administrat	ive Fee	27 TOTAL CHARLES AND TELE	XXX N.S. SUPPLIER:	XX 29	S TOS 9	Patient Spenddown 29 BALANCE DUE X XX.XX
SIGNATURE OF PRYSICIAN OR SIGNATURE OF PRYSI	SERVICE D UPPLIER IIIN THE STATEMENT THEREOF	PROCEDURE CODE INDENTIFY W6300 LUDING DEGREE(S) OR LENTS ON THE REVERSE AL	IEXPLAIN CCO	Administrat	ive Fee	27 TOTAL CHARLES I.M. 1 M. L.D. NOANY	XX XX N.S. SUPPLIER: PHONE NO Bill Willi town W	XX 29 ZB AI XX and/or gr ing ams	S TOS 9 MOUNT PAID XX X OUP NAME	Patient Spenddown 29 BALANCE DUE X XX.XX
SIGNATURE OF PRIVISICIAN OR SI CREDENTIALS II CERTIFY THAT THIS BILL AND ARE MADE A PAR	DEFINITE THE STATEMENT THE STATEMENT THEREOF	PROCEDURE CODE INDENTIFY W6300 LUDING DEGREESS OR RENTS ON THE REVERSE ALL OVIDER	IEXPLAIN CCO	Administrat	ive Fee	27 TOTAL CHARLES I.M. 1 M. L.D. NOANY	XX XX N.S. SUPPLIER: PHONE NO Bill Willi	XX 29 ZB AI XX and/or gr ing ams	S TOS 9 MOUNT PAID XX X OUP NAME	Patient Spenddown 29 BALANCE DUE X XX.XX